Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **ANJALI RAWTHER MOHAMMED RAFFI**	**Service Date**	:**17-Jul-2025** **Network** : Green
Card No	: **I005-029-121476931-01**	**Health Provider**	:**CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**
Policy Holder	: **ANJALI RAWTHER MOHAMMED RAFFI**	**Doctor's Name**	:**KEERTHANA**
Payer Name	: **DUBAI INSURANCE COMPANY**	**Co-Insurance**	:
TPA	: **E CARE - Blue Network**	**Remarks**	:
Validity	: **02-10-2024** To **01-10-2025**		
Gender	: **Female**		
Date Of Birth	: **28-Aug-1995**		
Patient's Tel No	: **0585886414**		

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : PC painful lump over right axilla since 3 days hopc Pt noticed a painful swelling in the right arm pit which later became infected No associated fever,bodypain Allergic to Amoxicillin Nil comorbs O\E Swelling present over right armpit tenderness present discharge plus **Duration:**

Vitals: Temp : 37 Bp :98 Pulse :84 Resp :18

Clinical Findings:

Diagnosis: L73.2 - Hidradenitis suppurativa,R52 - Pain, unspecified,R22.31 - Localized swelling, mass and lump, right upper limb, **Date of Onset** :17/38/2025

Requested Investigations: 10061, INCISION&DRAINAGE ABSCESS COMPLICATED/MULTIPLE,9, Consultation GP **Estimated Cost** :

Prescriptions: 0077-258502-1171 - (SODIUM AESCINATE : 20 MG) TABLETS, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : KEERTHANA **Stamp :**

د. كيرثانا راني باديبورايل ثارا
Dr. Keerthana Rani Padippurayil Thara
General Practitioner
License No.: 37864046-001
مـركـز سيتيكير الطبي ذ م م
CITICARE MEDICAL CENTER LLC

Signature :  **Date** : 17-Jul-2025

PATIENT'S DECLARATION :

I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Patient 's signature{Parent if minor} :  **Date :** 17-Jul-2025